



**THIS SIDE OF FORM SHOULD ONLY BE USED FOR AEMT RAPID RECERTIFICATION**

I, \_\_\_\_\_, serving in the capacity of Service Medical  
Director for \_\_\_\_\_ due affirm that  
\_\_\_\_\_ is deemed competent and qualified for admission to the  
State practical skills examination and subsequent State written certification examination in accordance  
with the State EMS Code (10 NYCRR 800) and the policies and procedures of the Bureau of Emergency  
Medical Services. I affirm that the applicant meets at minimum all the following criteria:

- \* **Actively practicing as a New York State certified AEMT within a regionally approved ALS system.**
- \* **Clinically competent and qualified to practice as an AEMT.**
- \* **Remains proficient in all of the cognitive and performance objectives of the New York State approved AEMT curriculum.**
- \* **In the judgement of the Service Medical Director the candidate is of sound character and judgement.**
- \* **Successfully completed the national cognitive and skills objectives in Basic Cardiac Life Support (BCLS), Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care as outlined in the *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care: Recommendations of the [most current] National Conference.***
- \* **Other requirements as set forth by the Service Medical Director.**

*The determination of whether a candidate meets the above criteria is made solely by the Service Medical Director and should be based on, but not limited to, direct clinical observation, evaluation of performance through quality improvement/quality assurance activities, in-service training and continuing medical education (CME).*

**Medical Director's Signature**

As the Service Medical Director for this applicant, I do hereby affirm that the applicant named above meets the criteria to participate in the AEMT Rapid Recertification examinations. In my judgement, the applicant is clinically competent and qualified to continue practicing as an AEMT. I understand this commitment is made under the sole authority of my license to practice medicine in the State of New York.

Medical Director's Name (Printed) \_\_\_\_\_

Medical Director's Signature \_\_\_\_\_

License Number: 

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**This is a two-sided form; it will not be processed unless both sides are completed, signed and submitted.**